



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

KULM MEDICAL PA
PO BOX 430
ROWLETT TX 75030

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-10-4169-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: ""

Amount in Dispute: \$806.40

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Upon receipt of the billing Texas Mutual audited the bills, reviewed the attached program documentation with each bill, and declined to issue payment stating the documentation did not support a work conditioning program was provided." "It appears that physical therapy was provided in abundance. The issue with Texas Mutual is that there is no obvious programmatic relationship between all the physical therapy and return to work."

Response Submitted by: Texas Mutual Insurance Co., 6210 W. Hwy 290, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 12, 2009 October 13, 2009 October 14, 2009 October 15, 2009 October 16, 2009 October 19, 2009 October 20, 2009	Work Conditioning Program CPT code 97545-WC	\$57.60/day	\$0.00
October 12, 2009 October 13, 2009 October 14, 2009 October 15, 2009 October 16, 2009 October 19, 2009 October 20, 2009	Work Conditioning Program CPT code 97546-WC (2 hours)	\$57.60/day	\$0.00

TOTAL		\$806.40	\$0.00
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FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204, titled *Medical Fee Guideline for Workers' Compensation Specific Services*, effective March 1, 2008, 33 TexReg 626, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated November 10, 2009

- CAC-16-Claim/service lacks information which is needed for adjudication. At least one remark code must be provided (May be comprised of either the remittance advice remark code or NCPDP reject reason code).
- 225-The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.

Explanation of benefits dated November 12, 2009

- CAC-16-Claim/service lacks information which is needed for adjudication. At least one remark code must be provided (May be comprised of either the remittance advice remark code or NCPDP reject reason code).
- 225-The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.

Explanation of benefits dated November 16, 2009

- CAC-16-Claim/service lacks information which is needed for adjudication. At least one remark code must be provided (May be comprised of either the remittance advice remark code or NCPDP reject reason code).
- 225-The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.

Explanation of benefits dated November 17, 2009

- CAC-16-Claim/service lacks information which is needed for adjudication. At least one remark code must be provided (May be comprised of either the remittance advice remark code or NCPDP reject reason code).
- 225-The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.

Explanation of benefits dated April 26, 2010

- CAC-W4-No additional reimbursement allowed after review of appeal/reconsideration.
- CAC-16-Claim/service lacks information which is needed for adjudication. At least one remark code must be provided (May be comprised of either the remittance advice remark code or NCPDP reject reason code).
- 225-The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
- 891-The insurance company is reducing or denying payment after reconsideration.

Explanation of benefits dated April 28, 2010

- CAC-W4-No additional reimbursement allowed after review of appeal/reconsideration.
- CAC-16-Claim/service lacks information which is needed for adjudication. At least one remark code must be provided (May be comprised of either the remittance advice remark code or NCPDP reject reason code).
- 225-The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
- 891-The insurance company is reducing or denying payment after reconsideration.

Issues

1. Did the requestor's documentation support billing for the disputed service.

Findings

1. The insurance carrier denied reimbursement for the work conditioning program based upon reason codes "CAC-16-Claim/service lacks information which is needed for adjudication. At least one remark code must be provided (May be comprised of either the remittance advice remark code or NCPDP reject reason code"; and

“225-The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.”

28 Texas Administrative Code §134.204(h) states “The following shall be applied to Return To Work Rehabilitation Programs for billing and reimbursement of Work Conditioning/General Occupational Rehabilitation Programs, Work Hardening/Comprehensive Occupational Rehabilitation Programs, Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs, and Outpatient Medical Rehabilitation Programs. To qualify as a Division Return to Work Rehabilitation Program, a program should meet the specific program standards for the program as listed in the most recent Commission on Accreditation of Rehabilitation Facilities (CARF) Medical Rehabilitation Standards Manual, which includes active participation in recovery and return to work planning by the injured employee, employer and payor or carrier.”

28 Texas Administrative Code §134.204(h)(2) For Division purposes, General Occupational Rehabilitation Programs, as defined in the CARF manual, are considered Work Conditioning.”

The CARF manual defines a occupational rehabilitation program as “individualized, focused on return to work, and designed to minimize risk to and optimize the work capability of the persons served. The services provided are integrative in nature, with the capability of addressing the work, health, and rehabilitation needs of those served. Such a program provides for service coordination and management of those persons served with injuries or illnesses. In view of the multiple stakeholders involved in Occupational Rehabilitation Programs, informed consent to obtain or share information about the persons served is provided by the persons served as required. The program may be provided as a hospital-based program, an outpatient program, or a private or group practice, and/or it may be provided in a work environment (at the job site).”

The submitted treatment notes indicate that the claimant participated in daily physical conditioning exercises. The requestor noted on all of the treatment notes under the heading “Work Simulation Activity: N/A”. The Division finds that the requestor’s documentation did not support a return to work focus or activities as defined by 28 Texas Administrative Code §134.204(h) and the CARF manual; as a result reimbursement cannot be recommended for a work conditioning program.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

5/7/2012

Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.